1 . The nurse is caring for the 4-year-old hospitalized with complications from chicken pox. Which type of precautions should the nurse plan?

A. Airborne and droplet precautions with negative- airflow room
B. Airborne and droplet precautions with positive- airflow room
C. Contact and droplet precautions with negative— airflow room
D. Standard precautions with reverse isolation and positive-airflow room

ANSWER: A

2. The medical resident admits the 4-year—old with complications related to chicken pox. Which prescribed medication is most important for the nurse to question?

A. Acetaminophen
B. Ampicillin
C. Acyclovir
D. Acetylsalicylic acid

ANSWER: D

3. The nurse is reviewing the serum laboratory results for the 10-Year-old diagnosed with chicken pox. Which value should be most concerning to the nurse? Place an X next to the value that is most concerning.

Serum Laboratory Test	Client's Value	Normal Levels
BUN	32	5–25 mg/dL
Creatinine	1.4	0.5–1.5 mg/ dL
Na	130	135–145 mEq/L
K	3.4	3.5–5.3 mEq/L
Cl	110	95–105 mEq/L
SGOT	75	0–42 units/L
Amylase	190	<200 units/L

ANSWER:

Serum Laboratory Test	Client's Value	Normal Levels
SGOT	75 X	0–42 units/L

4. The nurse on the pediatric unit is preparing to administer acetaminophen according to weight to the 6—year-old diagnosed with chicken pox. The recommended dose is 15 mg per kilogram. How many milligrams should the nurse give if the child weighs 54 1b?

_____ mg (Record your answer rounded to a whole number.)

ANSWER: 368

5. The 1-year-old with a temperature of 103°F (394°C) is diagnosed with roseola. Which information should the nurse provide to the parent? Select all that apply.

A. Expect a rose-pink rash that usually appears once the fever subsides.
B. Administer aspirin every 4 hours as needed for an elevated temperature.
C. Bathe the child in oatmeal baths twice daily to reduce the child's itching.
D. Avoid contact with the child's secretions and perform hand hygiene often-
E. Isolate the child from other family members until after the rash subsides.

ANSWER: A. D

6. The nurse is caring for the 5-year-old with rubeola. Which intervention by the nurse best ensures the child's comfort?

A. Ensure that the lights are dim and curtains drawn.
B. Provide baby oil baths to keep the skin moist.
C. Use a warm mist tent to loosen secretions-
D. Give a decongestant to reduce nasal drainage.

ANSWER: A

7. At 0800 hours the nurse assesses the 3-year-old with rubeola and finds that the child is restless, hard to calm, feverish, reporting pain, is tachycardic, and has crackles and rhonchi in the lung bases. The nurse compares the 0800-hour VS to the previously obtained VS (See VS chart). Acetaminophen was last given at 0600 hours. What should be the nurse's priority?

Vital Signs					
Time	1600	2000	2400	0400	0800
Pulse	110	115	120	126	130
Respiratory rate	20	24	26	30	40
Blood pressure (mm Hg)	108/64	110/60	100/60	110/76	120/80
Temperature	100.2°F (37.9°C)		101.6°F (38.7°C)		103.6°F (39.8°C)

A. Recheck the vital signs again in one-half hour.
B. Administer another dose of antipyretic medication.
C. Ensure that the chart is available and notify the HCP.
D. Implement airborne and standard infection precautions.

ANSWER: C

8. The nurse in the ED plans to assess three children: a 5-year-old with measles (rubeola), a 2—year-old with roseola, and a 6-year-old with rubella. Based on the severity of the infection, which child should the nurse plan to assess first?

A. The 2-year-old child with roseola
B. The 5—year-old child with rubeola
C. The 6-year-old child with rubella
D. Any of the three can be first

ANSWER: B

9. The clinic nurse is teaching the parent of the 3-year- old with rubella. Which information should the nurse provide?

A. "The period of communicability is 7 days before and 5 days after the rash appears; many cases are asymptomatic, and complications are rare-"
B. "You need to observe for pneumonia, a common complication; if pregnant, you do not need to worry about being exposed to rubella."
C. "The period of communicability is 5 days before and 14 days after the rash appears; there are no teratogenic effects from the virus on fetuses."
D. "The incubation period is 7 to 14 days; complications are rare, but those who are pregnant should not be exposed to rubella."

ANSWER: A

10. The nurse is assessing the 18-year-old diagnosed with mumps. Which findings should be most concerning to the nurse?

A. Parotid swelling, fever, headache
B. Earache, anorexia, painful chewing
C. Headache, stiff neck, photophobia
D. Vomiting, swelling above the jawline

ANSWER: C

11 . The 17-year-old student visits the high school nurse's office experiencing a sore throat, headache, fever of 101°F (383°C), malaise, and abdominal pain. How should the nurse plan to proceed?

A. Call the health care provider's office and send the student to be evaluated.
B. Give an antipyretic and have the student stay in the nursing office for an hour.
C. Ask if the student would like to go see the HCP for treatment or be sent home.
D. Call a parent and have the student go home with recommendations to see the HCP.

ANSWER: D

12. The nurse is discharging the 10-year-old who was hospitalized for RF with signs of CHF. What should be the nurse's priority with discharge teaching?

A. Allow time for the parents to talk about their feelings regarding their child's illness.
B. Inform the parents of the child's increased risk for infection when on a corticosteroid-
C. Ensure that the child is aware of the activity restrictions and the need for adherence.
D. Emphasize to the child that the rash on the trunk and the swollen joints will go away.

ANSWER: C

13. The nurse is presenting an educational session for other nurses on erythema and shows the picture illustrated. The nurse explains that, if observed, the person should see an HCP immediately because this erythema pattern is characteristic of which condition?



A. A bee sting
B. Cat scratch disease
C. A tick bite
D. Cellulitis

ANSWER: C

14. The nurse is caring for the adolescent diagnosed with Lyme disease. Which nursing problem should the nurse document in the plan of care?

A. Imbalanced nutrition: less than body requirements related to diarrhea
B. Disturbed sleep pattems related to hyperalert state
C. Impaired skin integrity related to pruritus
D. Acute pain: joint and muscle related to inflammation

ANSWER: D

15. The nurse completes teaching about doxycycline to the adolescent diagnosed with Lyme disease. The nurse recognizes the need for further education when the client makes which statement?

A. "I'm glad this isn't contagious so I can get back to tanning."
B. "I'll complete my entire dose of doxycycline even if I feel well."
C. "I should abstain from sexual intercourse while on doxycycline."
D. "I'll notify my health care provider if I get a fever or diarrhea."

ANSWER: A

16. The adolescent, who has been sick for several days, is being seen in a clinic with a tentative diagnosis of mononucleosis. Which findings should the nurse expect when assessing the client?

A. Weakness, loss of appetite, and extreme constipation
B. Fever, an enlarged spleen, and a rash similar to chicken pox
C. White coating on the throat and depressed lymphocyte levels
D. Extreme fatigue and enlarged lymph nodes in the neck and axilla

ANSWER: D

17. The college health nurse is teaching the student athlete diagnosed with infectious mononucleosis. The student asks, "Will I be able to play soccer after I rest up for a few days?" Which is the nurse's best response?

A. "You may not be physically active playing soccer for at least 3 months."
B. "You may be as active as you wish now if you are not feeling fatigued."
C. "There are no limitations on activity with infectious mononucleosis-"
D. "You need to avoid activities that can injure your abdomen for a few weeks."

ANSWER: D

18. The nurse is caring for the child who has a virulent infection. The HCP prescribes cefazolin sodium IV 50 mg every 6 hours. The Pediatric Dosage Handbook states the safe range of cefazolin is 6.25 to 25 mg per kg per day. The child weighs 18 1b. What is the most appropriate action by the nurse?

A. Notify the HCP because the dose is too high
B. Request pharmacy to send the correct dose
C. Administer cefazolin sodium as prescribed
D. Give 25 mg now and then 25 mg in 3 hours

ANSWER: C

19. The nurse is caring for four pediatric clients who have the skin conditions illustrated. For which client should the nurse expect to administer acyclovir orally?



ANSWER: B

20. The clinic nurse is preparing to assess the 14—year— old client who has impetigo on the hands and neck. In reviewing the client's history, the nurse would expect which predisposing factors to be associated with bacterial skin infections?

A. Diabetes insipidus, moisture, anorexia
B. Obesity, diabetes mellitus, eczema
C. Obesity, acne, congenital heart defect
D. Systemic corticosteroids, strabismus

ANSWER: B

21 . The nurse is cleansing the skin of the hospitalized child with impetigo. Which action is most important for the nurse to take?

A. Apply clean gloves to prevent the spread of the infection to others.

B. Use sterile technique to prevent any further infection of the lesions.
C. Ensure that the water is cold to help reduce pain during cleansing.
D. Keep the child in contact precautions until the child is discharged.

ANSWER: A

2 2. The clinic nurse is assessing the 17-year-old male and observes multiple lesions on both upper arms- Some of these lesions are covered with a honey- colored crust. Based on this assessment, which skin condition should the nurse consider?

A. Herpes zoster
B. Impetigo
C. Cellulitis
D. Ringworm

ANSWER: B

23. The nurse is teaching a parent skin care for the child diagnosed with impetigo. Which instruction is best?

A. Refrain from putting anything on the lesions.
B. Remove skin, crusts, and debris by debridement.
C. Avoid bathing the child until all scabs have healed.
D. Wash the skin and crusts daily with soap and water.

ANSWER: D

24. The nurse is caring for the 2-month-old newly hospitalized with pertussis (whooping cough). Which interventions, if prescribed, should the nurse implement? Select all that apply.

A. Erythromycin 15 mg/kg IV q6h.
B. Administer pertussis immune globulin.
C. Implement airborne isolation precautions.
D. Place suction equipment at the child's bedside.
E. Report the pertussis to the state health department.

ANSWER: A, B. D

25. The clinic nurse is teaching the mother of a child with head lice how to apply permethrin. Place the steps in the order that they should be performed.

A. Comb hair with fine-tooth or nit comb.
B. Thoroughly wet hair and scalp with permethrin lotion.
C. Ensure that the scalp and hair are dry.
D. Allow permethrin lotion to remain on hair for 10 minutes.
E. Massage permethrin into the hair one section at a Time

ANSWER: C, B, E, D, A

26. The school nurse is talking with the adolescent who is concerned about hair loss due to tinea capitis. Which response by the nurse is most appropriate?

A. “Others have gone through this. Would you like to talk with someone about this?”
B. “What did your primary health care provider tell you about your hair growing back?”
C. “You have styled your hair nicely to cover the bald spot; why is this bothering you?”
D. “Don’t worry. Although you lost hair, your hair will grow back in about 6 to 12 months.”

ANSWER: B

27. The clinic nurse is assessing the 12-year-old who has multiple scaly—ringed lesions on the face, neck, and arms. Which is the most important question that the nurse should ask?

A. “Do others at home have similar lesions?”
B. “When did these lesions first appear?”
C. “Do you have an animal in your house?”
D. “Have you been picking at these sores?”

ANSWER: C

28. The clinic nurse is advising the parent of the 8-year- old who has ringworm and now has an extensive, itchy rash. Which instruction should the nurse provide?

A. Use an over-the-counter topical steroid and an antihistamine to treat the reaction.
B. Bring the child immediately to the clinic for further assessment by a professional.
C. Observe for another 24 hours and call the clinic if the rash does not subside by then.
D. Stop all medication immediately because this could indicate an allergic reaction.

ANSWER: A

29. While caring for the 2-year-old child who has a colostomy, the nurse observes small threadlike objects on and around the stoma. Which statement correctly reflects the nurse’s thinking about these objects?

A. These are possible signs of a wound infection.
B. The objects may be indicative of hookworm.
C. The objects may be indicative of pinworms-
D. These are fibers left from the surgical procedure.

ANSWER: C

30. The nurse is providing information to the parents about how to obtain a test-tape specimen to determine if their child has pinworms. Place the nurse's instructions in the order that they should be completed for obtaining the specimen.

A. Place the tongue depressor in a glass jar or in a loose plastic bag.
B. Loop a piece of transparent tape, sticky side out, and place it on the end of a tongue depressor.
C. Repeat the procedure the following day.
D. Bathe the child.
E. As soon as the child wakes up in the morning and prior to the child having a bowel movement, place the tongue depressor firmly against the child's perianal area.

ANSWER: B, E, A, D, C

31 . The mother of the 13-year-old female tells the clinic nurse, "I hope that no one tries to get me to agree to have my daughter get that new vaccine that is supposed to prevent some STIs. My daughter is not and will not be having sex until she is married." What is the nurse's best response?

A. "How will you know whether or not your daughter is sexually active prior to marriage?"
B. "It seems that you have some questions about the vaccine. I will let the doctor know."
C. "I believe that you are talking about Gardasil. Tell me what you've heard about the vaccine."
D. "Here is a pamphlet that talks about the vaccine Gardasil that is used to prevent some STIs."

ANSWER: C

32. The nurse is assessing the adolescent involved in an MVA and notes the lesion illustrated and a rash on the client's trunk. What precaution should the nurse use to prevent the spread of this infection?



A. Standard precautions should be taken because the lesion appears to be syphilis.
B. Wash with soap and water after any contact with the client or the client's room.
C. Gloves should be worn whenever anyone has direct contact with the client's skin.
D. A mask, gown, and gloves should be worn and the client placed in an isolation room.

ANSWER: C

33. The nurse is assessing an adolescent male diagnosed with gonorrhea. Which specific signs and symptoms should the nurse associate with the gonorrheal infection? Select all that apply.

A. Subnormal temperature
B. Purulent urethral discharge
C. Dysuria and frequency
D. Lesions on the penis
E. Generalized skin rash

ANSWER: B. C

34. The nurse completes teaching an adolescent receiving treatment for an STI. Which statement indicates further teaching is needed?

A. "I should abstain from sexual intercourse while I am receiving treatment for chlamydia."
B. "If I use a latex rather than a nonlatex condom, there is less likelihood of it breaking."
C. "I'll apply podophyllin resin 10% solution to each wart and wash it off in I to 4 hours."
D. "There is no cure for genital herpes, but I'll be taking an analgesic and an antiviral drug."

ANSWER: A

35. The school nurse is reviewing the immunization record of the 8-year-old incoming student. Which finding warrants further follow-up by the nurse?

A. The client has received 2 doses of hepatitis A
B. The client has received 2 doses of hepatitis B
C. The client has received 5 doses of DTaP
D. The client has received 2 doses of MMR

ANSWER: B

36. An outbreak of hepatitis has occurred at a local factory. Ten factory workers ages 16 to 18 years developed symptoms of hepatitis within 2 days of each other. The source of the illness is determined to be contaminated cafeteria food. The factory occupational health nurse should notify the CDC that which type of hepatitis outbreak likely occurred?

A. Hepatitis A
B. Hepatitis B
C. Hepatitis C
D. Hepatitis D

ANSWER: A

37. During a home visit to the adolescent just diagnosed with hepatitis A, the nurse provides education to the client and family to prevent the spread of the disease. Which information should the nurse provide? Select all that apply.

A. The client should use strict hand washing after bowel movements.
B. Everyone should avoid eating raw foods for the next 2 weeks.
C. Use hot water when washing all the family's laundry together.
D. Clean the common toilet seat with bleach after each use by the client-
E. The client should avoid kissing anyone until symptoms disappear.

ANSWER: A, D

38. The nurse reviews the serology report of the hospitalized adolescent who has a history of ongoing IV drug use since age 13 years. After considering the serology report results, the nurse makes which correct conclusion?

Laboratory Test	Client Values	Normal Values
HBsAg	Positive	Negative
Anti-HBc IgM	Positive	Negative
AST	200 units/L	8–38 units/L
ALT	150 units/L	10–35 units/L

A. The client has acute hepatitis B, which can be transmitted by blood and body fluids.
B. The client had hepatitis B in the past, is currently immune, and cannot transmit it.
C. The client has acute hepatitis A, and contact precautions should be implemented.
D. The client is not currently infected with hepatitis, and no extra precautions are required.

ANSWER: A

39. The nurse completes teaching with an adolescent newly diagnosed with acute hepatitis C. Which statement indicates the need for additional teaching?

A. "I know that my liver will be enlarged for several more weeks."
B. "Once my jaundice is gone, I will be cured of my hepatitis C."
C. "I understand that my loss of appetite is related to my disease."
D. "My liver function will need to be monitored closely in the future."

ANSWER: B

40. The adolescent diagnosed with hepatitis is reporting pruritus. Which therapy should the nurse suggest?

A. Take a hot tub bath three times daily for a week.
B. Rub the skin well with a terry cloth bath towel.
C. Apply cool, moist compresses on the affected areas.
D. Use an exfoliating brush to scratch affected areas.

ANSWER: C

41 . The client being seen in a clinic relates a history of just returning on a flight from El Salvador after going mountain climbing. The client is diagnosed by the HCP as having giardiasis. Which conclusion should the nurse make regarding how the client most likely contracted the infection?

A. Giardiasis was acquired through the vaccinations required to travel in El Salvador.
B. Giardiasis was acquired through close contact with an ill person on the return flight.
C. Giardiasis was acquired when climbing in the mountains in El Salvador.
D. Giardiasis was acquired when consuming food and beverages prepared in El Salvador.

ANSWER: D

42. The nurse is preparing to review the HCP's written instructions with the parent of the pediatric client who has diarrhea caused by Escherichia coli (E. coli). Which instruction should the nurse question?

A. Child can consume the prediarrhea diet as tolerated.
B. Encourage the child to drink any beverage available.
C. Do not take the child to day care until diarrhea stops.
D. Do not give the child antidiarrheal medications.

ANSWER: B

43. The home health nurse is completing a follow-up visit at the home of the child recovering from a serious salmonella infection. The nurse should address a concern about reinfection with salmonella after noting that the family has which pets? Select all that apply.

A. The family has an indoor dog.
B. The family has a salamander.
C. The child has a large turtle.
D. The child's sister has a cat.
E. The family has baby chicks.

ANSWER: B. C. E

44. The adolescent client with acute vomiting and diarrhea is diagnosed at the clinic with a norovirus infection. Which instruction should the nurse include when teaching the client?

A. "Symptoms subside in l to 2 days; you can return to school and work and resume usual activities then."
B. "The virus can be present in the stool for 2 to 3 weeks after you feel better; strict hand washing is important."
C. "Wash soiled clothing in very hot water to destroy the virus; do this now and for 3 weeks after you feel better."
D. "The virus can be transmitted by respiratory droplets; be sure to wear a mask when in contact with others."

ANSWER: B

45. After receiving multiple mosquito bites and experiencing flu-like symptoms, the adolescent consults the school nurse and asks whether West Nile virus is a concern and whether an HCP appointment is necessary. Which statement should be the basis for the nurse's response?

A. Antiviral medications should be prescribed to destroy the West Nile virus infection.
B. Symptoms of West Nile virus can range from mild flu-like symptoms to fatal encephalitis.
C. If the client has West Nile virus, signs and symptoms will progressively worsen.
D. Insect repellent destroyed West Nile virus when the mosquito made skin contact.

ANSWER: B

46. The normally healthy adolescent client has a 5-mm skin induration 72 hours after receiving a tuberculin skin test. Which conclusions should the nurse make regarding the test results?

A. This 5-mm skin induration is negative for a normally healthy individual.
B. This finding indicates that active TB is present and treatment is needed.
C. This result is inconclusive, and a chest x-ray is needed to detect active TB.
D. The result is inaccurate; the site assessment occurred too long after the test.

ANSWER: A

47. The high school student is crying and says to the school nurse, "I had unprotected sex last week with someone who has been doing IV drugs; now I'm scared I might have HIV!" Which is the nurse's best initial response?

A. "Don't worry; I'm sure one incidence of unprotected sex will not cause you to contract HIV."
B. "You need to have a blood test immediately to test for the presence of HIV antigens."
C. "Have you talked to your parents about this so you can go in and get tested for HIV?"
D. "You're frightened because you think your actions may have caused you to contract HIV?"

ANSWER: D

48. The nurse is caring for the pediatric client who was diagnosed with AIDS. Which assessment findings should alert the nurse to the development of Pneumocystis carinii pneumonia (PCP)?

A. Dyspnea, elevated temperature, nonproductive cough, and fatigue
B. Weight loss, night sweats, persistent diarrhea, and hypothennia
C. Dysphagia, yellow-white plaques in the mouth, and sore throat
D. Lung crackles, chest pain, and small, painless purple—blue skin lesions

ANSWER: A

49. The adolescent client diagnosed with HIV has a CD4-positive T-lymphocyte count of 160 mcL. The nurse evaluates that interventions have been most effective when which outcome in the client's plan of care is achieved?

A. Soft, formed stools daily
B. Skin integrity nonintact
C. Free of opportunistic infections
D. Weight gain of 1 pound weekly

ANSWER: C

50. The nurse is planning care for the adolescent client being admitted with newly diagnosed active TB secondary to AIDS. Which intervention is most important for the nurse to plan?

A. Monitor for signs of bleeding.
B. Teach strategies for skin care.
C. Institute airborne precautions.
D. Assess CD4 and T-lymphocyte counts.

ANSWER: C